IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

HMO LOUISIANA, INC.,
5525 Reitz Ave.
Baton Rouge, LA 70809

Plaintiff,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201;

CENTERS FOR MEDICARE & MEDICAID SERVICES
7500 Security Boulevard
Baltimore, MD 21244;

XAVIER BECERRA, in his official capacity as Secretary of the United States Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.,
Washington, D.C., 20201; and

CHIQUITA BROOKS-LASURE, in her official capacity as Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244,

Defendants.

Case No.

VERIFIED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Plaintiff HMO Louisiana, Inc. ("HMOLA"), submits the following Verified Complaint for declaratory and injunctive relief against Defendants Department of Health and Human

Services ("HHS"), the Centers for Medicare & Medicaid Services ("CMS"), Xavier Becerra, in his official capacity as Secretary of HHS, and Chiquita Brooks-LaSure, in her official capacity as Administrator of CMS (collectively, "Defendants" or "CMS"), and alleges as follows:

INTRODUCTION

1. This is yet another case in which CMS has miscalculated a plan's Star Ratings through arbitrary and unlawful actions that, if uncorrected, will again have devastating and irreparable consequences to the plan and its members. Accordingly, HMOLA brings this action to obtain relief for the unlawful actions CMS has engaged in to calculate HMOLA's 2025 Star Ratings, which threaten to cause HMOLA to suffer immediate and irreparable harms to its reputation, market and competitive position, and more importantly, undermine HMOLA's effort to retain approximately 30,000[1] Medicare beneficiaries healthy and independent.

2. CMS's actions, and its refusal to address them administratively and in compliance with its own regulations, are a disturbing, if textbook, example of rigid and unreasonable agency decision-making that should be set aside under the Administrative Procedure Act ("APA").

3. HMOLA is one of the nation's Medicare Advantage health plans ("MA Plans"), currently serving approximately 30,000 members in Louisiana.

4. MA Plans, like HMOLA, receive annual Star Ratings from CMS for their contracts based on "health and drug plan quality and performance measures" that are used by Medicare beneficiaries to shop for plans.

5. CMS calculates the Star Ratings based on a clear and unambiguous methodology that includes the consideration of all relevant data for a given contract. That methodology and

[1] As of October 15, 2024, HMOLA's current enrollment of Medicare beneficiaries is 29,890.

related requirements are set forth in specific regulations that CMS promulgated and must abide by.

6. Among other requirements, CMS has regulations that address how to calculate Star Ratings for MA Plans when they consolidate multiple MA contracts under a single surviving H contract.

7. Fluctuations in an MA Plan's Star Ratings can occur in the short term following contract consolidation. Thus, during the first two years following consolidation, Star Ratings for the surviving contract are based on both the surviving and consolidated contracts' data.

8. CMS further implements an analytical adjustment, referred to as the Categorical Adjustment Index ("CAI"), to a contract's Star Ratings to mitigate disparities within contract performance.

9. On January 1, 2024, HMOLA's parent company, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA"), consolidated contracts belonging to HMOLA (contract H6453) and another subsidiary (contract H5576), with HMOLA's H6453 contract surviving.

10. Consistent with its regulations, CMS should have based its Star Ratings for HMOLA's contract on data from both H5576 and H6453.

11. But in calculating the 2025 Star Ratings for HMOLA, CMS applied an entirely different and new methodology that was not subject to any formal notice and comment rulemaking, and that directly contradicted the plain text of its own regulation.

12. Instead of using data from both contracts to calculate 2025 Star Ratings, CMS only considered data from the surviving contract H6453 for two Part C and D measures. CMS's own system in fact *prevented* HMOLA from submitting data for two measures for contract

H5576. And CMS further incorrectly calculated the CAI factor by only considering enrollment data from the surviving contract.

13. When HMOLA confronted the agency about its use of incomplete data, CMS asserted it was justified to do so for vague and incorrect reasons.

14. The result was catastrophic: HMOLA's 2025 Star Ratings dropped precipitously, from 4 to 3.5 Stars.

15. Indeed, CMS intends to publicly disclose HMOLA's unlawfully calculated Star Ratings on its public website on October 15, 2024, which if it proceeds in full, will result in irreparable harm to HMOLA's reputation, goodwill, and competitive position, as well as impair its ability to attract beneficiaries.

16. CMS's failure to adhere to its articulated methodology to calculate HMOLA's Star Ratings constitutes an unexplained and unreasonable departure from its own regulation.

17. CMS further irrationally and unreasonably considered incomplete data when calculating HMOLA's 2025 Star Ratings.

18. CMS's refusal to follow its own promulgated methodology and reliance on flawed data are arbitrary and capricious agency actions in stark violation of the APA.

19. CMS's 2025 Star Ratings for HMOLA should be vacated, and this matter should be remanded to the agency to adjust HMOLA's 2025 Star Ratings based on a proper application of its regulation and use of complete data.

20. To prevent HMOLA from suffering irreparable harm from CMS's unlawful conduct, and in light of the public release of the 2025 Star Ratings, the Court should expedite the resolution of this matter on the merits, restrain CMS from disseminating or relying on its

improper Star Ratings for HMOLA, and require CMS to announce, publish, and distribute HMOLA's 2024 Star Ratings until it correctly recalculates HMOLA's 2025 Star Rating.

PARTIES

21. HMOLA is a Louisiana business corporation, with its principal place of business in Baton Rouge, Louisiana, and is a wholly-owned subsidiary of BCBSLA, which is a non-profit, mutual insurance company.

22. Defendant HHS is the department of the federal government ultimately responsible for the federal Medicare and Medicaid programs.

23. HHS has delegated its authority to administer the Medicare and Medicaid programs to Centers for Medicare and Medicaid Services. *See* 66 Fed. Reg. 35437.

24. Defendant CMS is a federal agency within HHS with the primary oversight responsibility for the Medicare program and the federal portion of the Medicaid program. It was created by the Reorganization Act of March 9, 1977. *See* 66 Fed. Reg. 35437.

25. Defendant Xavier Becerra is named in his official capacity as the Secretary of HHS. *See* 42 C.F.R. § 405.1136(d)(1).

26. Defendant Chiquita Brooks-LaSure is named in her official capacity as Administrator of the Centers for Medicare and Medicaid Services. The Administrator is responsible for the administration of the Medicare program, including the Star Ratings. *Id.*

JURISDICTION & VENUE

27. This Court has jurisdiction over this case pursuant to 28 U.S.C. § 1331 because this action arises under the APA, 5 U.S.C. §§ 701 *et seq.*, and 42 U.S.C. §§ 1395 *et seq.*

28. Venue is proper in this Court under 28 U.S.C. § 1391(e) because this is an action against officers and agencies of the United States and a substantial part of the events giving rise to HMOLA's claims occurred in this District.

29. The Complaint is timely under 28 U.S.C. § 2401(a).

REGULATORY AND FACTUAL BACKGROUND

The Medicare Program And Star Ratings

30. The Medicare program, authorized under Title XVIII of the Social Security Act ("SSA"), is a federal program that provides health insurance benefits for Americans aged 65 years and older and certain disabled persons. *See* 42 U.S.C. §§ 1395 *et seq.*

31. The Centers for Medicare and Medicaid Services is the federal agency responsible for administering the Medicare program.

32. Individuals enrolled in Medicare may elect to receive their benefits under Part C of the Medicare program, commonly referred to as the "Medicare Advantage" program, as an alternative to original Medicare.

33. Under Part C, CMS contracts with private insurance payors, commonly known as Medicare Advantage Plans ("MA Plans"), to provide and arrange for Medicare-covered benefits for Medicare beneficiaries who enroll in their benefit plan. *See* 42 C.F.R. § 422.4.

34. Besides arranging and paying the Medicare-covered benefits of Medicare beneficiaries, MA Plans typically provide supplemental benefits as well as lower co-payments and other cost sharing, which further reduce the cost of covered services for beneficiaries.

35. The Medicare Advantage program is intended to shift the financial risk of providing health care to beneficiaries from the federal government to the privately run MA Plans in exchange for a per-member, per-month payment.

36. MA Plans that are better at keeping their members healthy, by effectively managing their care and providing important related services, receive higher Star Ratings, and overall, perform better in the marketplace. *See generally* 42 C.F.R. § 422.160.

37. By providing additional benefits beyond those covered by Medicare, MA Plans compete with original Medicare and with one another to convince beneficiaries to select their plan.

38. In an effort to encourage MA Plans to offer high quality plans and to assist Medicare beneficiaries in selecting a plan, CMS studies and surveys MA Plans for quality, compliance, and other metrics to develop numerical ratings for each MA Plan ("Star Ratings").

39. The Star Ratings are based on a five-star scale, with 1 star being the lowest rating and 5 stars being the highest. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

40. The Star Ratings are designed to be "a true reflection of the plan's quality" and must be based on data that is "complete, accurate, reliable, and valid." 83 Fed. Reg. 16440, 16521 (Apr. 16, 2018).

41. Star Ratings information is widely available to Medicare beneficiaries to consider when choosing to enroll in an MA Plan. These measures are particularly important, as they allow beneficiaries to compare health plans based on quality.

42. CMS prominently displays Star Ratings in its online and print resources on available MA Plans as required under the SSA. *See* 42 U.S.C. § 1395w–21.

43. Indeed, through the online Medicare Plan Finder tool, CMS displays MA Plans in highest to lowest Star Ratings order to prospective members, with the express purpose of guiding beneficiaries to higher-rated plans first.

44. CMS also introduced the Categorical Adjustment Index ("CAI") to address the average within-contract disparity in performance among beneficiaries who receive a low-income subsidy, are dual eligible, and/ or have a disability.[2]

45. CMS then adjusts a plan's Star Ratings upwards or downwards based on the percentage of these beneficiaries.

46. The Star Ratings also impact the amount of funds CMS will pay to each MA Plan.

47. Under Section 1853(o) of the SSA, CMS allocates quality bonuses to MA Plans based on their Star Ratings and awards additional funds to MA Plans rated at or above 4 stars. *See* 42 U.S.C. § 1395w–23.

48. MA Plans use these bonuses, which are often in the tens, if not hundreds of millions, of dollars, to provide additional benefits and services to further improve care to their members.

49. Conversely, MA Plans that consistently receive Star Ratings below 3 stars may be terminated from the Medicare Advantage program altogether. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

50. Thus, the Star Ratings have tremendous value to MA Plans and are strong incentives for these plans to provide quality care and comprehensive benefits to their members, allow them to compete in the marketplace, receive higher compensation, and even remain eligible to continue to participate in the Medicare Advantage program.

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[2] *See Categorical Adjustment Index (CAI) Methodology*, Ctrs. for Medicare & Medicaid Servs., available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Supplement-for-Categorical-Adjustment-Index-.pdf.

Calculation Of Star Ratings Generally

51. To calculate Star Ratings, CMS must use clear and unambiguous calculations established in its regulations. *See* 42 C.F.R. § 422.162(b); 42 C.F.R. § 422.166(h)(1)(ii).

52. Star Ratings for MA Plans are based on a calculation of numerous performance measures designed to assess member satisfaction and receipt of care, including but not limited to preventative health services, management of long-term conditions, member experiences with the health plan, member complaints, and customer service.[3]

53. CMS publishes these measures and the specifications that it uses to develop its Star Ratings. MA Plans (including HMOLA) use them to target areas of improvement and investment to ensure they are maximizing their services for beneficiaries, and in turn, earn higher Star Ratings.

54. Any changes to the Star Ratings calculations can have serious, and sometimes catastrophic, impacts on MA Plans.

55. When Star Ratings fall due to changes in criteria and calculation methodology, MA Plans may be disqualified from receiving quality bonus payments and can even be removed from the Medicare Advantage program altogether, resulting in devastating financial and coverage consequences for MA Plans and beneficiaries.

56. Therefore, in developing each MA Plan's Star Ratings, CMS must treat each MA Plan "fairly and equally," judging them only on matters that are "under the control of the health or drug plan," in a system that will "minimize unintended consequences" adopted through a

[3] *See* Medicare 2025 Part C & D Star Ratings Technical Notes at 30–105, CENTERS FOR MEDICARE AND MEDICAID SERVICES, https://www.cms.gov/files/document/2025-star-ratings-technical-notes.pdf.

"process of developing [a ratings methodology that] is transparent and allows for multi-stakeholder input." 83 Fed. Reg. 16440, 16521.

57. CMS calculates Star Ratings based on a rigid methodology – set forth in its own regulations – that focuses on "health and drug plan quality and performance measures." 42 C.F.R. § 422.166; Medicare 2025 Part C & D Star Ratings Technical Notes at 3–5 & 30–105.

58. Measures used to calculate Star Ratings can be grouped into two categories: those from the Consumer Assessment of Healthcare Providers and Systems surveys ("CAHPS"), and those from "non-CAHPS" sources. Medicare 2025 Part C & D Star Ratings Technical Notes at 3 & 30–105.

59. CAHPS measures relate to member experience with healthcare providers, services, and plans, deriving data from "surveys that ask consumers and patients to evaluate the interpersonal aspects of health care." 42 C.F.R. § 422.162(a).

60. Non-CAHPS measures derive data from sources other than CAHPS surveys. *See* Medicare 2025 Part C & D Star Ratings Technical Notes, at 5. Non-CAHPS measures consist of data from, among other sources, the Healthcare Effectiveness Data and Information Set[4] and CMS's Part C and D reporting requirements. *Id.*

61. Each CAHPS and non-CAHPs measure is given a numeric score. *Id.* at 3.

62. The agency then determines the "cut point" for each measure – that is, the range of scores that correspond with particular Star Ratings. Together, the CAHPS and non-CAHPS measure scores and cut points are combined to develop each MA Plan's Star Ratings.

[4] The Healthcare Effectiveness Data and Information Set ("HEDIS") is a tool used by more than 90 percent of U.S. health plans to measure performance on important dimensions of care and service. More than 190 million people are enrolled in health plans that report quality results using HEDIS. *See* Healthcare Effectiveness Data and Information Set (HEDIS) - Healthy People 2030 | health.gov (last visited Oct. 15, 2024).

CMS Adopts The Categorical Adjustment Index As Part Of The Star Ratings Methodology

63. Because Star Ratings are awarded on a contract level, CMS adopted the CAI to address disparities in performance by MA contracts with multiple plans.

64. Specifically, the CAI factor adjusts a contract's Star Ratings upwards or downwards to adjust for the average within-contract disparity in performance for Low Income Subsidy/Dual Eligible ("LIS/DE") beneficiaries and disabled beneficiaries. *See* Medicare 2025 Part C & D Star Ratings Technical Notes at 15–17.

65. The CAI value or factor depends on the contract's percentage of beneficiaries with LIS/DE and the contract's percentage of beneficiaries with disabled status. *Id.*

66. The CAI factor is then applied to the contract's Star Ratings. 42 C.F.R. § 422.166(f)(2).

67. In 2024, CMS promulgated a regulation to establish a new methodology for the calculation of CAI factors for contracts that have recently consolidated. *See* 89 Fed. Reg. 30448; 42 C.F.R. § 422.166(f)(2).

68. When consolidation involves "two or more contracts for health or drug services of the same plan type under the same parent organization, the enrollment data . . . are combined *across the surviving and consumed contracts* in the consolidation." 42 C.F.R. § 422.166(f)(2)(B)(1) (emphasis added).

69. Thus, under the new regulation, CMS must use the enrollment data of the surviving and consumed contracts to determine the consolidated contract's final adjustment category, which is then used to finalize the consolidated contract's Star Ratings.

70. If CMS's resulting calculation results in a positive number, then it will increase the Star Ratings for the consolidated contract. Medicare 2025 Part C & D Star Ratings Technical Notes at 16–17.

71. CMS had to apply its revised CAI methodology immediately, meaning that the methodology would be applied to 2025 Star Ratings and going forward. *Compare* 42 C.F.R. §§ 422.166(f)(1) & (3), *with* 42 C.F.R. § 422.166(f)(2).

72. CMS acknowledged this fact in its own regulatory commentary, in which it provided an example of the CAI factor methodology applied to 2025 Star Ratings. *See* 89 Fed. Reg. 30644.

CMS's Arbitrary Departure From Its Own Regulations To Calculate The 2025 Star Ratings Caused HMOLA's Star Ratings To Drop

73. Based on its high-quality care and services, HMOLA has historically received top-tier Star Ratings that are critical to its operations and ability to serve its members.

74. HMOLA received Star Ratings of 4.5 out of 5 in 2023 and 2024.

75. On January 1, 2024, BCBSLA, the parent corporation of HMOLA, consolidated contracts H5576 and H6453. Following that contract consolidation, HMOLA's contract H6453 survived.

76. In September 2024, CMS notified HMOLA and other MA Plans of the second plan preview for their 2025 Star Ratings.

77. HMOLA's preliminary 2025 Star Ratings dropped precipitously to *3.5 Stars* – instead of its expected 4.0 Stars.

78. HMOLA immediately contacted CMS for an explanation of the sudden and surprising drop in its Star Ratings.

79. In response, CMS advised that "the change in methodology for calculating the CAI in the case of contract consolidations [was] effective beginning with the 2027 Star Ratings." *See* Exhibit ("Ex.") 1, CMS Correspondence on Oct. 3, 2024.

80. That is to say, in computing HMOLA's 2025 Star Ratings and CAI adjustment factor, CMS only used enrollment data for one of the MA contracts, contract H6453, instead of using enrollment data for both MA contracts, including contract H5576.

81. But CMS's own regulation does not provide for any deferred implementation of the CAI. *See* 42 C.F.R. § 422.166(f)(2).

82. To the contrary, the relevant part of the regulation *omits* a delayed implementation, unlike other provisions. *Compare* 42 C.F.R. §§ 422.166(f)(1) & (3), *with id.* § 422.166(f)(2).

83. Nevertheless, CMS departed from the express methodology set forth in the regulation and refused to consider enrollment data from the surviving and consumed contract in calculating the CAI adjustment factor.

84. Thus, HMOLA's 2025 Star Ratings significantly dropped as a result of CMS's failure to apply its own regulations.

85. Had CMS followed the regulation as written, HMOLA's Star Ratings would have been 4 Stars, rather than 3.5 Stars.

86. CMS's failure to follow its own regulation resulted in the very thing that the CAI was intended to prevent: fluctuations in Star Ratings for MA contracts with multiple plans that consolidate.

87. HMOLA alerted CMS to its flawed methodology, explaining the regulation requires CMS to use enrollment data from the surviving and consumed contracts in the

consolidation. *See* Ex. 2, Notification of Calculation Errors on Sept. 12, 2024; 42 CFR § 422.166(f)(2)(i)(B)(1).

88. HMOLA also advised CMS that this flawed approach undermines the purpose and policy of the regulation to obtain a complete representation of plan performance when calculating Star Ratings. *See* Ex. 2.

89. Calculating the CAI factor for a newly consumed contract with only data from the surviving contract is inconsistent with the plain and express language of the regulation, which calls for use of enrollment data from both the surviving *and consumed* contract. *See* 42 C.F.R. §§ 422.166(f)(2) & 422.166(f)(2)(i)(B)(1).

90. It also frustrates the very purpose of CMS's CAI factor, which is to mitigate within-contract performance disparities by preventing dramatic swings in Star Ratings post-consolidation that can have massive adverse impacts on MA Plans and beneficiaries.

91. By its express terms, CMS's regulation does not permit the agency to delay implementation of the CAI factor to consolidated plans' Star Ratings. *See* Ex. 2; 42 C.F.R. § 422.166(f)(2).

92. When confronted with the flaws in its approach, CMS asserted that statements in its final rule related to delayed implementation somehow permitted its departure from the regulation's actual text. Ex. 1; 89 Fed. Reg. 30644; 89 Fed. Reg 30645.

93. CMS further asserted that this methodology was properly delayed until the calculation of the 2027 Star Ratings, *see* Ex. 1, but the plain text of the regulation did not defer implementations of the CAI factor until 2027, 42 C.F.R. § 422.166(f)(2).

94. Indeed, CMS's own regulatory commentary provides an example of the CAI factor methodology using the *2025* Star Ratings – a point that the CMS did not even acknowledge in responding to HMOLA. *See* 89 Fed. Reg. 30644.

95. Despite HMOLA's efforts to resolve its concerns informally, CMS has doggedly refused to meaningfully engage with HMOLA or reconsider its flawed approach and grave impacts of it.

CMS Used Other Flawed And Improper Data To Calculate HMOLA's Star Ratings

96. CMS also relied on incomplete data for two process measures – D11 "MTM Program Completion Rate for CMR" and C05 "Special Needs Plan (SNP) Care."

97. CMS only considered the data submitted by the surviving contract, H6453, for these two process measures.

98. When contracts are consolidated, the Star Ratings for the surviving contract for the two years after consolidation is determined through the enrollment-weighted average of the measures of the consumed contract and surviving contract for all measures except improvement measures. *See* 42 CFR § 422.162(b)(3)(ii); Medicare 2025 Part C & D Star Ratings Technical Notes, Attachment B, at 114.

99. Thus, to accurately calculate the Star Rating for contract H6453, which was consolidated in January 2024, CMS had to include data from contract H5576 and contract H6453 in its calculations.

100. However, only data from H6453 was considered in the calculation of D11 and C05.

101. In fact, HMOLA attempted to submit information on H5576 and H6453 to CMS for use in calculating its Star Ratings.

102. Because of the limitations with CMS's own portal, HMOLA could only submit information for these measures for the surviving contract, H6453, and could not provide data for the consumed contact, H5576.

103. There was no submission option available on CMS's portal to submit the necessary data for the subsumed contract, H5576.

104. When HMOLA brought this technical error to CMS's attention, CMS summarily dismissed it by noting it had not received data for these measures for the consumed contract and was "following the technical specifications for these measures." Ex. 1.

105. CMS overlooked these errors in calculating HMOLA's Star Ratings, which had the predicable and dire consequence of lowering its ratings.

106. The consideration of incomplete data for just one of these two measures triggered a reduction in HMOLA's Star Ratings.

Defendants' Unlawful Conduct
Will Cause HMOLA to Suffer Irreparable Harm

107. CMS's refusal to abide their own regulation threatens to cause HMOLA to suffer severe and irreparable harm.

108. By applying some newfound methodology to calculate CAI factors for consolidated contracts, rather than its actual regulation, Defendants have used incomplete data to calculate HMOLA's Star Ratings.

109. Defendants have further improperly refused to consider complete data for process measures D11 and C05.

110. As a result, Defendants have issued fundamentally flawed Star Ratings for HMOLA of 3.5 Stars.

111. The correction of just one of these two errors would increase HMOLA's final Star Ratings from 3.5 to 4.0.

112. The impact of that significant drop in HMOLA's Star Ratings is serious and substantial.

113. The reduced Star Ratings have undermined HMOLA's competitive position, reputation, and goodwill, and impacted its ability to compete against other plans, including those that may have benefited from Defendants' flawed and unlawful methodology.

114. Additionally, as a result of CMS's flawed rating methodology and reliance on partial data, beneficiaries may, based on its Star Ratings, mistakenly conclude HMOLA's offerings are inferior or lower in quality compared to the offerings of other plans.

115. And by reducing HMOLA's 2025 Star Ratings, CMS has rendered HMOLA ineligible for quality bonus payments in 2026, thereby impacting its operations and ability to provide enhanced benefits and lower premiums to beneficiaries.

116. HMOLA has tried to resolve the parties' dispute informally to no avail. Exs. 1–3.

117. Left with no other option, HMOLA turns to this Court to require Defendants to comply with federal law, vacate the flawed Star Ratings assigned to HMOLA, and enjoin them from disclosing and relying on that unlawful rating in connection with any other agency decision.

COUNT I
(Violation Of 5 U.S.C. § 706(2)(A) – Against All Defendants)
(Use Of Surviving Contract Enrollment Data)

118. HMOLA realleges the allegations set forth in Paragraphs 1 through 117 of this Complaint as if fully set forth herein.

119. Defendants' decision to use solely the surviving contract enrollment data to calculate HMOLA's CAI factor and apply such to HMOLA's 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2) and 42 C.F.R. § 422.166(f)(2).

120. HMOLA is adversely affected and aggrieved by Defendants' action.

121. Defendants' decision not to use both surviving and consumed contract enrollment data to calculate CAI factors is arbitrary and capricious and contrary to law.

122. Defendants failed to engage in reasoned decision-making; to reasonably (or at all) explain their departure from CMS's own regulation; or to provide an adequate and reasonable explanation for their decision.

123. Defendants' action flies in the face of the plain and unambiguous text of their own regulation and undermines the policy and purpose of that regulation to alleviate disparities between MA plans in the same MA contract, which in turn harms MA beneficiaries.

124. Defendants acted unreasonably and contrary to law by deploying a methodology that is inconsistent with the approach mandated by their regulation, and was never disclosed to regulated parties – let alone adopted pursuant to any proper rulemaking proceedings.

125. As a result, Defendants' decision is arbitrary, capricious, and otherwise not in accordance with the law in violation of 5 U.S.C. § 706(2)(A).

126. HMOLA has suffered and will continue to suffer irreparable harm as a result of Defendants' violations of 5 U.S.C. § 706(2)(A).

127. HMOLA is entitled to injunctive and declaratory relief to remedy Defendants' unlawful conduct, as well as all other relief as set forth in its Prayer for Relief. *See* 5 U.S.C. § 705.

COUNT II
(Violation Of 5 U.S.C. § 706(2)(A) – Against All Defendants)
(Failure To Consider H5576 Data For Measure D11)

128. HMOLA realleges the allegations set forth in Paragraphs 1 through 117 of this Complaint as if fully set forth herein.

129. CMS's failure to consider D11 data from H5576 to calculate HMOLA's Part D 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2) and 42 C.F.R. § 422.162(b)(3)(ii).

130. HMOLA is adversely affected and aggrieved by the use of this incomplete data measure.

131. Defendants' decision not to consider H5576's data relating to Measure D11 is arbitrary and capricious and contrary to law.

132. Defendants failed to engage in a reasoned decision-making; to consider important aspects of the problem they believed they faced; to consider the impact that the incomplete data would have on HMOLA's Star Ratings; to provide an adequate explanation for their decision to consider incomplete data to determine HMOLA's Star Ratings; and considered the incomplete data even though contrary evidence demonstrated it should never have been considered as is.

133. The use of this data to calculate HMOLA's 2025 Star Ratings is arbitrary, capricious, and otherwise not in accordance with the law in violation of 5 U.S.C. § 706(2)(A).

134. HMOLA has suffered and will continue to suffer irreparable harm as a result of Defendants' violations of 5 U.S.C. § 706(2)(A).

135. HMOLA is entitled to injunctive and declaratory relief to remedy Defendants' unlawful conduct, as well as all other relief as set forth in its Prayer for Relief. *See* 5 U.S.C. § 705.

COUNT III
(Violation Of 5 U.S.C. § 706(2)(A) – Against All Defendants)
(Failure To Consider H5576 Data For Measure C05)

136. HMOLA realleges the allegations set forth in Paragraphs 1 through 117 of this Complaint as if fully set forth herein.

137. CMS's failure to consider C05 data from H5576 to calculate HMOLA's Part D 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2) and 42 C.F.R. § 422.162(b)(3)(ii).

138. HMOLA is adversely affected and aggrieved by the use of this incomplete data measure.

139. Defendants' decision to not consider H5576's data relating to Measure C05 is arbitrary and capricious and contrary to law.

140. Defendants failed to engage in a reasoned decision-making; to consider important aspects of the problem they believed they faced; to consider the impact that the incomplete data would have on HMOLA's Star Ratings; to provide an adequate explanation for their decision to consider incomplete data to determine HMOLA's Star Ratings; and considered the incomplete data even though contrary evidence demonstrated it should never have been considered as is.

141. The failure to consider C05 data from H5576 to calculate HMOLA's 2025 Star Ratings is arbitrary, capricious, and otherwise not in accordance with the law in violation of 5 U.S.C. § 706(2)(A).

142. HMOLA has suffered and will continue to suffer irreparable harm as a result of Defendants' violations of 5 U.S.C. § 706(2)(A).

143. HMOLA is entitled to injunctive and declaratory relief to remedy Defendants' unlawful conduct, as well as all other relief as set forth in its Prayer for Relief. *See* 5 U.S.C. § 705.

COUNT IV
Declaratory Judgment

144. HMOLA realleges and incorporates Paragraphs 1 through 117 as if fully set forth herein.

145. CMS's calculation of the 2025 Star Ratings is a final agency action made reviewable by 5 U.S.C. § 706(2).

146. HMOLA is adversely affected and aggrieved by the calculation of its Star Ratings, and flawed calculation and application of the CAI factor.

147. An actual controversy has arisen and exists between HMOLA and Defendants regarding Defendants' calculation of HMOLA's 2025 Star Ratings using incomplete measure data and application of an erroneous CAI factor.

148. HMOLA requests a declaration from this Court under 28 U.S.C. § 2201 that Defendants' calculation is arbitrary and capricious.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff HMOLA prays that this Court enjoin HMOLA's 2025 Star Ratings and remand this matter to the agency for further consideration. Additionally, HMOLA requests the Court to:

1. Adopt an expedited schedule to resolve the merits of this Complaint;

2. Declare that:

- Defendants' calculation of the CAI and subsequent application to HMOLA's 2025 Star Ratings directly conflicts with CMS's regulatory requirements and is arbitrary and capricious in violation of 5 U.S.C. § 706(2)(A);

- Defendants' consideration of incomplete D11 measure data to calculate HMOLA's 2025 Star Ratings is arbitrary and capricious in violation of 5 U.S.C. § 706(2)(A);

- Defendants' consideration of incomplete C05 measure data to calculate HMOLA's 2025 Star Ratings is arbitrary and capricious in violation of 5 U.S.C. § 706(2)(A); and

- Defendants must recalculate HMOLA's 2025 Star Ratings in compliance with CMS's regulations, specifically taking into account data from H5576 for Measures D11 and C05 and taking into consideration data from both the surviving and consumed contracts for the CAI factor.

3. An emergency temporary restraining order and preliminary injunction:

   - Preventing Defendants from announcing, publishing, or distributing HMOLA's erroneous 2025 Star Ratings;

   - Preventing Defendants from relying on HMOLA's 2025 Star Ratings in connection with any further agency action, including with but not limited to quality bonus payment determinations; and

   - Requiring Defendants to announce, publish, and distribute HMOLA's 2024 Star Ratings until they correctly recalculate HMOLA's 2025 Star Rating.

4. Award HMOLA its reasonable attorney's fees and costs, as permitted by law; and

5. Grant such other further relief as this Court deems just and proper.

Dated: October 17, 2024

By: _____

Paul Werner (D.C. Bar #482637)
SHEPPARD, MULLIN, RICHTER & HAMPTON LLP
2099 Pennsylvania Ave N.W., Suite 1000
Washington, D.C. 20006
Tel. 202-747-1900
pwerner@sheppardmullin.com

Counsel for Plaintiff

DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the factual statements contained in the Verified Complaint related to HMOLA are true and correct to the best of my knowledge and belief.

Sheldon Faulk
SVP and COO, Government Business
Executed on October 16, 2024

CIVIL COVER SHEET

JS-44 (Rev. 11/2020 DC)

I. (a) PLAINTIFFS
HMO Louisiana, Inc.

(b) COUNTY OF RESIDENCE OF FIRST LISTED PLAINTIFF _____
(EXCEPT IN U.S. PLAINTIFF CASES)

DEFENDANTS
U.S. Dep't of Health & Human Servs., Centers for Medicare & Medicaid Servs., XAVIER BECERRA, in his official capacity as Secretary of Health & Human Servs., and CHIQUITA BROOKS-LASURE, in her official capacity as Administrator o

COUNTY OF RESIDENCE OF FIRST LISTED DEFENDANT _____
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED

(c) ATTORNEYS (FIRM NAME, ADDRESS, AND TELEPHONE NUMBER)
Paul Werner
Sheppard, Mullin, Richter & Hampton LLP
2099 Pennsylvania Avenue, NW, Suite 100
Washington, D.C. 20006
(202) 747-1900

ATTORNEYS (IF KNOWN)

II. BASIS OF JURISDICTION
(PLACE AN x IN ONE BOX ONLY)

- ○ 1 U.S. Government Plaintiff
- ○ 3 Federal Question (U.S. Government Not a Party)
- ◉ 2 U.S. Government Defendant
- ○ 4 Diversity (Indicate Citizenship of Parties in item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (PLACE AN x IN ONE BOX FOR PLAINTIFF AND ONE BOX FOR DEFENDANT) **FOR DIVERSITY CASES ONLY!**

	PTF	DFT		PTF	DFT
Citizen of this State	○ 1	○ 1	Incorporated or Principal Place of Business in This State	○ 4	○ 4
Citizen of Another State	○ 2	○ 2	Incorporated and Principal Place of Business in Another State	○ 5	○ 5
Citizen or Subject of a Foreign Country	○ 3	○ 3	Foreign Nation	○ 6	○ 6

IV. CASE ASSIGNMENT AND NATURE OF SUIT

(Place an X in one category, A-N, that best represents your Cause of Action and one in a corresponding Nature of Suit)

○ A. *Antitrust*
- ☐ 410 Antitrust

○ B. *Personal Injury/ Malpractice*
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Medical Malpractice
- ☐ 365 Product Liability
- ☐ 367 Health Care/Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Product Liability

◉ C. *Administrative Agency Review*
- ☒ 151 Medicare Act

Social Security
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

Other Statutes
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 890 Other Statutory Actions (If Administrative Agency is Involved)

○ D. *Temporary Restraining Order/Preliminary Injunction*

Any nature of suit from any category may be selected for this category of case assignment.

(If Antitrust, then A governs)

○ E. *General Civil (Other)* OR **○ F. *Pro Se General Civil***

Real Property
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent, Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

Personal Property
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

Bankruptcy
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

Prisoner Petitions
- ☐ 535 Death Penalty
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Conditions
- ☐ 560 Civil Detainee – Conditions of Confinement

Property Rights
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent – Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016 (DTSA)

Federal Tax Suits
- ☐ 870 Taxes (US plaintiff or defendant)
- ☐ 871 IRS-Third Party 26 USC 7609

Forfeiture/Penalty
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

Other Statutes
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 430 Banks & Banking
- ☐ 450 Commerce/ICC Rates/etc
- ☐ 460 Deportation
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions
- ☐ 470 Racketeer Influenced & Corrupt Organization
- ☐ 480 Consumer Credit
- ☐ 485 Telephone Consumer Protection Act (TCPA)
- ☐ 490 Cable/Satellite TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes
- ☐ 890 Other Statutory Actions (if not administrative agency review or Privacy Act)

○ **G. *Habeas Corpus/ 2255***	○ **H. *Employment Discrimination***	○ **I. *FOIA/Privacy Act***	○ **J. *Student Loan***
☐ 530 Habeas Corpus – General ☐ 510 Motion/Vacate Sentence ☐ 463 Habeas Corpus – Alien Detainee	☐ 442 Civil Rights – Employment (criteria: race, gender/sex, national origin, discrimination, disability, age, religion, retaliation) *(If pro se, select this deck)*	☐ 895 Freedom of Information Act ☐ 890 Other Statutory Actions (if Privacy Act) *(If pro se, select this deck)*	☐ 152 Recovery of Defaulted Student Loan (excluding veterans)
○ **K. *Labor/ERISA (non-employment)***	○ **L. *Other Civil Rights (non-employment)***	○ **M. *Contract***	○ **N. *Three-Judge Court***
☐ 710 Fair Labor Standards Act ☐ 720 Labor/Mgmt. Relations ☐ 740 Labor Railway Act ☐ 751 Family and Medical Leave Act ☐ 790 Other Labor Litigation ☐ 791 Empl. Ret. Inc. Security Act	☐ 441 Voting (if not Voting Rights Act) ☐ 443 Housing/Accommodations ☐ 440 Other Civil Rights ☐ 445 Americans w/Disabilities – Employment ☐ 446 Americans w/Disabilities – Other ☐ 448 Education	☐ 110 Insurance ☐ 120 Marine ☐ 130 Miller Act ☐ 140 Negotiable Instrument ☐ 150 Recovery of Overpayment & Enforcement of Judgment ☐ 153 Recovery of Overpayment of Veteran's Benefits ☐ 160 Stockholder's Suits ☐ 190 Other Contracts ☐ 195 Contract Product Liability ☐ 196 Franchise	☐ 441 Civil Rights – Voting (if Voting Rights Act)

V. ORIGIN

● 1 Original Proceeding ○ 2 Removed from State Court ○ 3 Remanded from Appellate Court ○ 4 Reinstated or Reopened ○ 5 Transferred from another district (specify) ○ 6 Multi-district Litigation ○ 7 Appeal to District Judge from Mag. Judge ○ 8 Multi-district Litigation – Direct File

VI. CAUSE OF ACTION (CITE THE U.S. CIVIL STATUTE UNDER WHICH YOU ARE FILING AND WRITE A BRIEF STATEMENT OF CAUSE.)

Admin. Procedures Act (5 USC 706 et seq); Arbitrary & capricious agency action by CMS for Star Ratings calculation

VII. REQUESTED IN COMPLAINT ☐ CHECK IF THIS IS A **CLASS ACTION** UNDER F.R.C.P. 23 **DEMAND $** **JURY DEMAND:** Check YES only if demanded in complaint **YES** ☐ **NO** ☒

VIII. RELATED CASE(S) IF ANY (See instruction) **YES** ☐ **NO** ☒ If yes, please complete related case form

DATE: October 17, 2024 **SIGNATURE OF ATTORNEY OF RECORD** /s/ Paul Werner

INSTRUCTIONS FOR COMPLETING CIVIL COVER SHEET JS-44
Authority for Civil Cover Sheet

The JS-44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and services of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. Listed below are tips for completing the civil cover sheet. These tips coincide with the Roman Numerals on the cover sheet.

I. COUNTY OF RESIDENCE OF FIRST LISTED PLAINTIFF/DEFENDANT (b) County of residence: Use 11001 to indicate plaintiff if resident of Washington, DC, 88888 if plaintiff is resident of United States but not Washington, DC, and 99999 if plaintiff is outside the United States.

III. CITIZENSHIP OF PRINCIPAL PARTIES: This section is completed only if diversity of citizenship was selected as the Basis of Jurisdiction under Section II.

IV. CASE ASSIGNMENT AND NATURE OF SUIT: The assignment of a judge to your case will depend on the category you select that best represents the primary cause of action found in your complaint. You may select only one category. You must also select one corresponding nature of suit found under the category of the case.

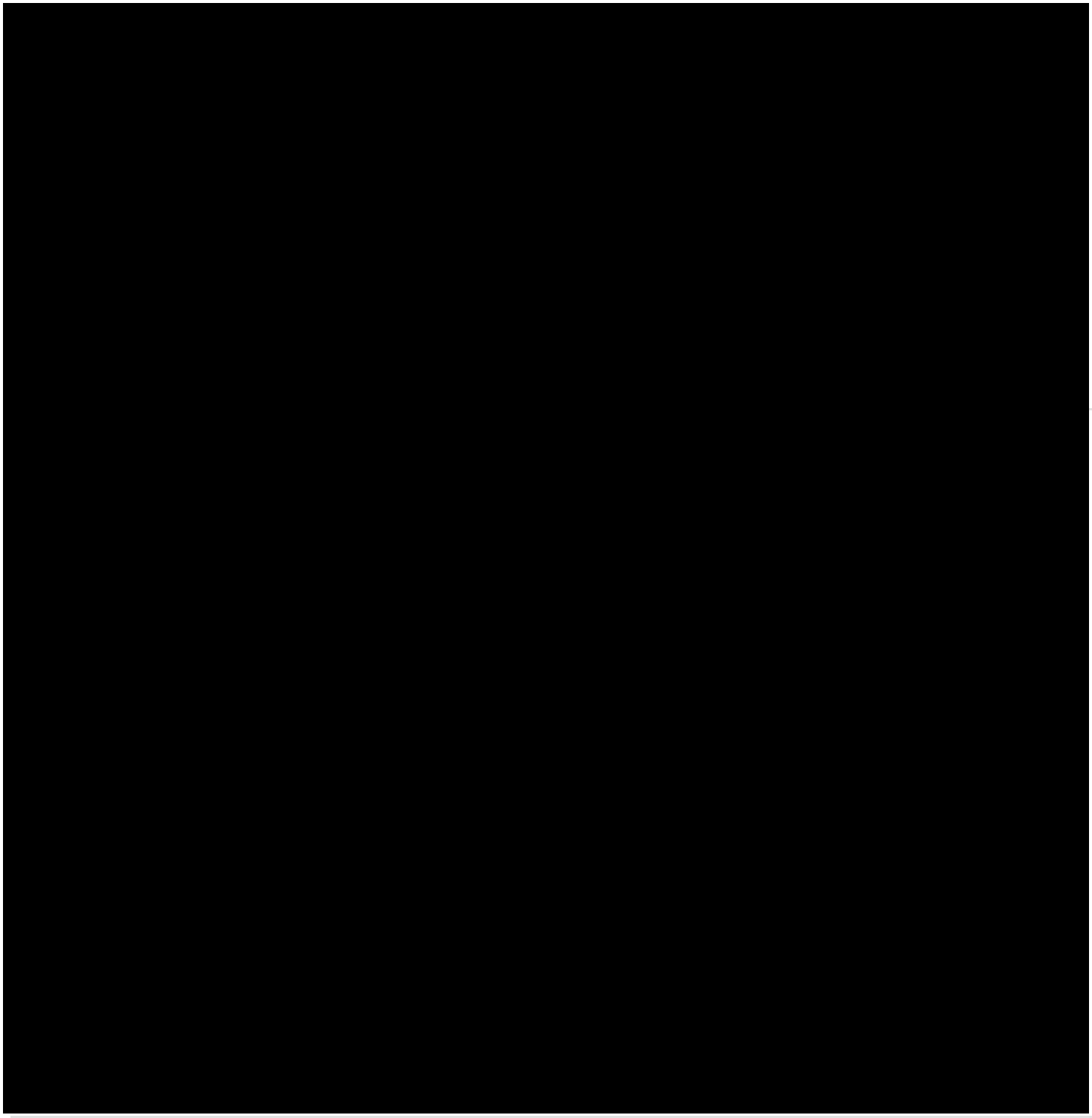
VI. CAUSE OF ACTION: Cite the U.S. Civil Statute under which you are filing and write a brief statement of the primary cause.

VIII. RELATED CASE(S), IF ANY: If you indicated that there is a related case, you must complete a related case form, which may be obtained from the Clerk's Office.

Because of the need for accurate and complete information, you should ensure the accuracy of the information provided prior to signing the form.

EXHIBIT 1

(CMS Correspondence on Oct. 3, 2024)



From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, October 3, 2024 1:16 PM
To: Miller, Wesley <Wesley.Miller@lablue.com>
Cc: Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 H6453

For the first two issues you raised related to the MTM and SNP care management measures, we are following the technical specifications for these measures. Data are not collected and validated for contracts that terminate prior to July 1 in the following year after the contract year (CY) reporting period (i.e., terminated contracts are not required to report any data for the respective two years – the CY reporting period, and the following year). Based on this, we did not receive data for H5576 to use for these measures in the 2025 Star Ratings. Since H6453 did not offer SNP plans during the measurement year, there are no data for H6453 for the SNP care management measure. Based on this, H6453 received a missing data message of 'No data available' for this measure. For the MTM measure, we calculated the measure score for H6453 as we would whenever there are missing data not due to a data integrity issue for a contract in a consolidation. We calculated the enrollment weighted average score for all contracts in the consolidation with non-missing data. In this case, that resulted in only the measure score from H6453 being used.

For the third issue raised related to the CAI, we disagree that this change in methodology applies beginning with the 2025 Star Ratings. In the 2025 final rule, we finalized the change in methodology for calculating the CAI in the case of contract consolidations effective beginning with the 2027 Star Ratings, consistent with our policy of only applying Star Ratings calculation changes prospectively to future measurement years (here, the 2025 measurement year), and not to measurement periods that have already begun or been completed. At 89 FR 30644 we stated – "We proposed to calculate the percentage of LIS/DE enrollees and percentage of disabled enrollees used to determine the CAI adjustment factor in the case of contract consolidations based on the combined contract enrollment from all contracts in the consolidation beginning with the 2027 Star Ratings." At 89 FR 30645, we stated – "…we are finalizing the revision at §§422.166(f)(2)(i)(B) and 423.186(f)(2)(i)(B) to calculate the percentage LIS/DE enrollees and the percentage disabled enrollees for the surviving contract for the first 2 years following a consolidation by combining the enrollment data for the month of December for the measurement period of the Star Ratings year across all contracts in the consolidation as proposed without modification." CMS did not receive any comments to the proposed rule about the application of this change beginning with the 2027 Star Ratings. Since the updated CAI calculation methodology was finalized as proposed without modification, it applies beginning with the 2027 Star Ratings. Based on this, the CAI for H6453 for the 2025 Star Ratings was calculated using only data from H6453 consistent with current practice and what was displayed at the second plan preview period.

For the reasons explained above, we will not be making any changes to the 2025 Star Ratings for H6453.

Thank you,

Part C and D Star Ratings Team

From: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Sent: Thursday, September 12, 2024 7:41 PM
To: Miller, Wesley <Wesley.Miller@lablue.com>
Cc: Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Subject: RE: Plan Preview #2 H6453

Confirming receipt.

From: Miller, Wesley <Wesley.Miller@lablue.com>
Sent: Thursday, September 12, 2024 7:14 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>
Cc: Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>

Subject: Plan Preview #2 H6453
Importance: High

Good Afternoon,

Thank you for allowing Plans the opportunity to provide feedback on the Star Rating calculation prior to finalization.

Pursuant to the CMS Memorandum dated September 5, 2024 ("Second Plan Preview of 2025 Part C and D Star Ratings Data"), HMO Louisiana, Inc. ("HMOLA") is providing notice of three (3) calculation errors identified in the Second Plan Preview STAR Ratings for its contract H6453. These calculation errors impact HMOLA's contract H6453, which is the surviving contract following a consolidation in 2024, and result from the failure to account for data from the consumed contract (H5576). These errors include:

1) HMOLA was unable to submit relevant measurement information data relating to D11: "MTM Program Completion Rate for CMR," which data would have resulted in an increase of this measure from 92% (4 Stars) to 95% (5 Stars).

2) HMOLA was unable to submit relevant measurement information data relating to C05: "Special Needs Plan (SNP) Care Management," which data would have resulted in an increase of this measure from No Star Rating to 96% (5 Stars).

3) The Categorical Adjustment Index ("CAI") applied to HMOLA's contract (H6453) failed to account for enrollment data across all contracts that had been consolidated into the surviving contract. Had the enrollment data been properly applied, the CAI applied to HMOLA's contract would have changed from -0.033597 to 0.002506.

The current STAR rating for HMOLA's contract (H6453) is 3.74957 (3.5 Stars). If the above errors are corrected, the new adjusted rating for the contract would increase to 3.80839 (4.0 Stars). Notably, the correction of even one (1) of these errors would result in an increase of HMOLA's final STAR Rating from a 3.5 to a 4.0. Therefore, if not corrected, these errors would result in a material financial impact to HMOLA in terms of loss of additional STAR quality bonus payments, which may result in fewer benefits and higher costs for members in future years. **Attached to this correspondence is an Appendix that details the calculation errors and the effect on the overall STAR Rating.**

While we provided you with the additional information in the accompanying Appendix (including the data for measurements D11 and C05) that evidence the calculation errors, we believe the summary below provides all of the information necessary for CMS to understand the errors we have identified and correct them prior to finalization of CY 2025 STAR Ratings data.

History of Contract H6453

Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA") is the parent company to HMOLA. Prior to 2024, BCBSLA and/or its subsidiaries offered products under the following H-Contracts:

- Vantage Health Plan, Inc. offered a MA HMO-POS product under **H5576** contract
- HMOLA offered a MA HMO product under **H6453** contract
- BCBSLA offered a MA PPO product under **H1248** contract
- Primewell Health Services of Mississippi, Inc. offered a MA HMO-POS product under **H7163** contract
- Primewell Health Services of Arkansas, Inc. offered a MA HMO-POS product under **H2722** contract

Effective January 1, 2024, BCBSLA consolidated contracts H5576 (offered by Vantage Health Plan, Inc.) and H6453 (offered by HMOLA), with HMOLA's contract H6453 as the surviving contract. Contracts H1248 (BCBSLA), H7163 (Primewell Health Services of Mississippi, Inc.), and H2722 (Primewell Health Services of Arkansas, Inc.) remain active and were not affected by the consolidation. HMOLA's contract H6453 is only contract at issue for the purposes of this communication. The consolidation of contracts H5576 (the consumed contract) and H6453 (the surviving contract) directly led to the calculation errors noted above.

Errors # 1 and 2: Failure to Consider Relevant Data for Measures D11 and C05

When contracts are consolidated, the STAR Rating for the surviving contract for the first year after consolidation is determined through the enrollment-weighted average of the measures of both the consumed contract and the surviving contract for all measures except improvement measures. Both the regulation addressing STAR Ratings following contract consolidations as well as current technical instructions for STAR Ratings contain this requirement that data from both contracts be included for the first two years following a contract consolidation. *See* 42 CFR § 422.162(b)(3)(ii); Medicare 2025 Part C & D Star Ratings Technical Notes, Appendix B, p. 115 (Draft) (Sept. 4, 2024) ("Technical Notes"). Thus, to accurately calculate the STAR Rating for contract H6453, CMS must include data from both contract H5576 and H6453 in its calculations. However, only data from HH6453 was considered in the calculation of D11 and C05.

Despite its relevance to the STAR Rating calculation for the surviving contract, HMOLA was unable to submit data for two measures for contract H5576 due to a technical issue with HPMS. Specifically, HMOLA was unable was able to submit measurement information relating to measurements D11 "MTM Program Completion Rate for CMR" and C05 "Special Needs Plan (SNP) Care," both of which are process measures. HMOLA was only able to submit information for these measures for contract H6453. As such, CMS used only partial information for these measures and, in doing so, failed to adhere to its own regulations. Again, had the relevant data been submitted relating to contract H5576, HMOLA's score for D11 would be 95%/5 Stars (as opposed to the calculated 92%/4 Stars), and HMOLA's score for C05 would be 96%/5 Stars (as opposed to the calculated No Star Rating). Both the regulations governing contract consolidation and CMS's Technical Notes require CMS to include all relevant data for the consumed contract when calculating the STAR Rating for the surviving contract. Accordingly, HMOLA requests that CMS recalculate the measure values for contract H6453 using data for measurements D11 and C05 for contract H5576.

Error # 3: Incorrect Calculation of CAI

The consolidation of contracts H5576 and H6453 also led to an incorrect calculation of the CAI for HMOLA contract H6453. The regulation governing application of the CAI states that, for the first two years following a consolidation, CMS determines the CAI using enrollment data from both the surviving and consumed contracts in the consolidation. 42 CFR § 422.166(f)(2)(i)(B)(1). This requirement was added to the regulation in April 2024, and the text of the regulation indicates that it became effective immediately. This is in contrast to the language addressing the calculation of the HEI reward following contract consolidation, which the regulation specifies will go into effect beginning with the 2027 STAR Ratings year. 42 CFR § 422.166(f)(2).[1] In the case of the CAI, there is nothing in the text of the regulation that suggests that the methodology for applying the CAI following a contract consolidation should not go into effect immediately. *See SCAN Health Plan v. Dep't of Health and Human Services*, No. 1:23-cv-03910-CJN, Dkt. No. 33 (D.D.C. June 3, 2024) ("[T]he real dividing point between the portions of a final rule with and without legal force is designation for publication in the Code of Federal Regulations" (citation omitted).).

To comply with the requirements in Section 422.166(f)(2), CMS must include in its CAI calculation the enrollment data from the consumed contract regarding beneficiaries who are dually eligible, receive the low-income subsidy, or have disability status. Using enrollment data from both the surviving and the consolidated contracts to determine the CAI adjustment factor is consistent with how CMS assesses plan performance in other contexts following a contract consolidation. As noted above, the regulations require CMS to combine measure-level data

between contracts in the first two years following a consolidation. The purpose of this approach is to obtain a complete representation of plan performance when calculating STAR Ratings. Calculating a weighted average of performance data across contracts appropriately represents consolidated performance.

Prior to the April 2024 amendments, Section 422.166 did not address how to calculate the CAI adjustment factor after a contract consolidation. The Technical Notes are also silent on this issue. In the absence of a specific exception made for the calculation of the CAI adjustment factor, the default rule of weighing data from both the consumed and surviving contracts (as reflected in Section 422.162) should have applied to the current calculation of HMOLA's CAI, in compliance with the specific requirement in Section 422.166(f)(2). Accordingly, HMOLA requests that CMS recalculate the CAI factor for contract H6453 using enrollment data for contract H6453 and contract H5576.[2]

Please contact us if you believe any further information is necessary or if you are unable to validate these errors. We are happy to answer any questions you may have related to any of these issues. Otherwise, we thank you for your review and consideration and look forward to your response.

Thank you,

Wesley Miller, PAHM, Notary Public
Medicare Compliance Officer
Louisiana Blue
o (225) 298-7965

Please visit us at lablue.com/social

Upcoming PTO:

LOUISIANA BLUE

[1] Similarly, when CMS changed the weights given to certain measures, it amended the regulation to specify that the new weights would go into effect starting with the 2026 STAR Ratings year. 42 CFR § 422.166(e)(1)(iii)-(iv).

[2] In the alternative, CMS has the authority, in the absence of any regulatory requirement to the contrary, to calculate the CAI in this manner following a consolidation. In light of the limited number of consolidations that occur in any given year, this rule could easily be applied to any other similarly situated organizations. For CMS to take the alternative approach for CY 2025 STAR Ratings, after already articulating that this was the "more accurate" approach, would be arbitrary and capricious.

EXHIBIT 2

(Notification of Calculation Errors on Sept. 12, 2024)

LOUISIANA BLUE

September 12,2024

Dear Sir or Madam,

Pursuant to the CMS Memorandum dated September 5, 2024 ("Second Plan Preview of 2025 Part C and D Star Ratings Data"), HMO Louisiana, Inc. ("HMOLA") is providing notice of three (3) calculation errors identified in the Second Plan Preview STAR Ratings for its contract H6453. These calculation errors impact HMOLA's contract H6453, which is the surviving contract following a consolidation in 2024, and result from the failure to account for data from the consumed contract (H5576). These errors include:

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2) HMOLA was unable to submit relevant measurement information data relating to C05: "Special Needs Plan (SNP) Care Management," which data would have resulted in an increase of this measure from No Star Rating to 96% (5 Stars).

3) The Categorical Adjustment Index ("CAI") applied to HMOLA's contract (H6453) failed to account for enrollment data across all contracts that had been consolidated into the surviving contract. Had the enrollment data been properly applied, the CAI applied to HMOLA's contract would have changed from -0.033597 to 0.002506.

The current STAR rating for HMOLA's contract (H6453) is 3.74957 (3.5 Stars). If the above errors are corrected, the new adjusted rating for the contract would increase to 3.80839 (4.0 Stars). Notably, the correction of even one (1) of these errors would result in an increase of HMOLA's final STAR Rating from a 3.5 to a 4.0. Therefore, if not corrected, these errors would result in a material financial impact to HMOLA in terms of loss of additional STAR quality bonus payments, which may result in fewer benefits and higher costs for members in future years. **Attached to this correspondence is an Appendix that details the calculation errors and the effect on the overall STAR Rating.**

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- Vantage Health Plan, Inc. offered a MA HMO-POS product under **H5576** contract
- HMOLA offered a MA HMO product under **H6453** contract

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(225) 295-3307 | Fax (225) 295-2054

LOUISIANA BLUE

- BCBSLA offered a MA PPO product under **H1248** contract
- Primewell Health Services of Mississippi, Inc. offered a MA HMO-POS product under **H7163** contract
- Primewell Health Services of Arkansas, Inc. offered a MA HMO-POS product under **H2722** contract

Effective January 1, 2024, BCBSLA consolidated contracts H5576 (offered by Vantage Health Plan, Inc.) and H6453 (offered by HMOLA), with HMOLA's contract H6453 as the surviving contract. Contracts H1248 (BCBSLA), H7163 (Primewell Health Services of Mississippi, Inc.), and H2722 (Primewell Health Services of Arkansas, Inc.) remain active and were not affected by the consolidation. HMOLA's contract H6453 is only contract at issue for the purposes of this communication. The consolidation of contracts H5576 (the consumed contract) and H6453 (the surviving contract) directly led to the calculation errors noted above.

Errors # 1 and 2: Failure to Consider Relevant Data for Measures D11 and C05

When contracts are consolidated, the STAR Rating for the surviving contract for the first year after consolidation is determined through the enrollment-weighted average of the measures of both the consumed contract and the surviving contract for all measures except improvement measures. Both the regulation addressing STAR Ratings following contract consolidations as well as current technical instructions for STAR Ratings contain this requirement that data from both contracts be included for the first two years following a contract consolidation. *See* 42 CFR § 422.162(b)(3)(ii); Medicare 2025 Part C & D Star Ratings Technical Notes, Appendix B, p. 115 (Draft) (Sept. 4, 2024) ("Technical Notes"). Thus, to accurately calculate the STAR Rating for contract H6453, CMS must include data from both contract H5576 and H6453 in its calculations. However, only data from HH6453 was considered in the calculation of D11 and C05.

Despite its relevance to the STAR Rating calculation for the surviving contract, HMOLA was unable to submit data for two measures for contract H5576 due to a technical issue with HPMS. Specifically, HMOLA was unable was able to submit measurement information relating to measurements D11 "MTM Program Completion Rate for CMR" and C05 "Special Needs Plan (SNP) Care," both of which are process measures. HMOLA was only able to submit information for these measures for contract H6453. As such, CMS used only partial information for these measures and, in doing so, failed to adhere to its own regulations. Again, had the relevant data been submitted relating to contract H5576, HMOLA's score for D11 would be 95%/5 Stars (as opposed to the calculated 92%/4 Stars), and HMOLA's score for C05 would be 96%/5 Stars (as opposed to the calculated No Star Rating). Both the regulations governing contract consolidation and CMS's Technical Notes require CMS to include all relevant data for the consumed contract when calculating the STAR Rating for the surviving contract. Accordingly, HMOLA requests that CMS recalculate the measure values for contract H6453 using data for measurements D11 and C05 for contract H5576.

Error # 3: Incorrect Calculation of CAI

The consolidation of contracts H5576 and H6453 also led to an incorrect calculation of the CAI for HMOLA contract H6453. The regulation governing application of the CAI states that, for the first two

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years following a consolidation, CMS determines the CAI using enrollment data from both the surviving and consumed contracts in the consolidation. 42 CFR § 422.166(f)(2)(i)(B)(1). This requirement was added to the regulation in April 2024, and the text of the regulation indicates that it became effective immediately. This is in contrast to the language addressing the calculation of the HEI reward following contract consolidation, which the regulation specifies will go into effect beginning with the 2027 STAR Ratings year. 42 CFR § 422.166(f)(2).[1] In the case of the CAI, there is nothing in the text of the regulation that suggests that the methodology for applying the CAI following a contract consolidation should not go into effect immediately. *See SCAN Health Plan v. Dep't of Health and Human Services*, No. 1:23-cv-03910-CJN, Dkt. No. 33 (D.D.C. June 3, 2024) ("[T]he real dividing point between the portions of a final rule with and without legal force is designation for publication in the Code of Federal Regulations" (citation omitted).).

To comply with the requirements in Section 422.166(f)(2), CMS must include in its CAI calculation the enrollment data from the consumed contract regarding beneficiaries who are dually eligible, receive the low-income subsidy, or have disability status. Using enrollment data from both the surviving and the consolidated contracts to determine the CAI adjustment factor is consistent with how CMS assesses plan performance in other contexts following a contract consolidation. As noted above, the regulations require CMS to combine measure-level data between contracts in the first two years following a consolidation. The purpose of this approach is to obtain a complete representation of plan performance when calculating STAR Ratings. Calculating a weighted average of performance data across contracts appropriately represents consolidated performance.

Prior to the April 2024 amendments, Section 422.166 did not address how to calculate the CAI adjustment factor after a contract consolidation. The Technical Notes are also silent on this issue. In the absence of a specific exception made for the calculation of the CAI adjustment factor, the default rule of weighing data from both the consumed and surviving contracts (as reflected in Section 422.162) should have applied to the current calculation of HMOLA's CAI, in compliance with the specific requirement in Section 422.166(f)(2). Accordingly, HMOLA requests that CMS recalculate the CAI factor for contract H6453 using enrollment data for contract H6453 and contract H5576.[2]

Please contact us if you believe any further information is necessary or if you are unable to validate these errors. We are happy to answer any questions you may have related to any of these issues. Otherwise, we thank you for your review and consideration and look forward to your response.

Sheldon Faulk, JD, MBA
SVP and COO, Government Business
Louisiana Blue

[1] Similarly, when CMS changed the weights given to certain measures, it amended the regulation to specify that the new weights would go into effect starting with the 2026 STAR Ratings year. 42 CFR § 422.166(e)(1)(iii)-(iv).

[2] In the alternative, CMS has the authority, in the absence of any regulatory requirement to the contrary, to calculate the CAI in this manner following a consolidation. In light of the limited number of consolidations that occur in any given year, this rule could easily be applied to any other similarly situated organizations. For CMS to take the alternative approach for CY 2025 STAR Ratings, after already articulating that this was the "more accurate" approach, would be arbitrary and capricious.

EXHIBIT 3

(CMS Correspondence on Oct. 14, 2024)

[redacted]

Louisiana

From: Duran, Vanessa (CMS/CM) <Vanessa.Duran@cms.hhs.gov>
Sent: Tuesday, October 15, 2024 3:10 PM
To: Patalano, Lou <Lou.Patalano@lablue.com>; CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Rice, Cheri (CMS/CM) <Cheri.Rice@cms.hhs.gov>; Newsom, Mark (CMS/CM) <mark.newsom@cms.hhs.gov>

Cc: Miller, Wesley <Wesley.Miller@lablue.com>; Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Guillory, Daniel <Daniel.Guillory@lablue.com>
Subject: RE: Plan Preview #2 H6453

Mr. Patalano: Acknowledging receipt. Our team is reviewing the additional information you sent yesterday and we'll follow up as quickly as we can.

Best regards,
Vanessa

Vanessa Duran | Director | Medicare Drug Benefit & Part C & D Data Group | Center for Medicare | Centers for Medicare & Medicaid Services | Cell: 443-324-9311 | Office: 410-786-8697 | vanessa.duran@cms.hhs.gov

From: Patalano, Lou <Lou.Patalano@lablue.com>
Sent: Monday, October 14, 2024 4:46 PM
To: CMS PartC&DStarRatings <PartCandDStarRatings@cms.hhs.gov>; Rice, Cheri (CMS/CM) <Cheri.Rice@cms.hhs.gov>; Duran, Vanessa (CMS/CM) <Vanessa.Duran@cms.hhs.gov>; mark.newsome@cms.hhs.gov
Cc: Miller, Wesley <Wesley.Miller@lablue.com>; Saporito, Mary <Mary.Saporito@lablue.com>; Faulk, Sheldon <Sheldon.Faulk@lablue.com>; Guillory, Daniel <Daniel.Guillory@lablue.com>; Patalano, Lou <Lou.Patalano@lablue.com>
Subject: RE: Plan Preview #2 H6453
Importance: High

Dear Ms. Rice, Ms. Duran, and Mr. Newsome:
I am Chief Legal Officer for Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("BCBSLA") and its subsidiary, HMO Louisiana, Inc. ("HMOLA"). BCBSLA appreciates the opportunity to address the issues regarding the calculation of the Star Ratings for contract H6453 ("Surviving Contract"). In our September 12, 2024 letter, HMOLA identified three (3) errors in the Star Ratings for the Surviving Contract that render the ratings arbitrary, capricious, and contrary to law. CMS indicated on October 3, 2024 that it would not make any adjustments to the Star Ratings for the Surviving Contract. As further detailed in the attached correspondence, we disagree with CMS's reasoning and respectfully reiterate our request that CMS recalculate the 2025 Star Ratings for the Surviving Contract in accordance with applicable regulatory requirements.

To be clear, CMS's errors resulted in the overall Star Rating for the Surviving Contract to be decreased from 3.80839 (4.0 Stars) to 3.74957 (3.5 Stars), a downgrade that will result in imminent, irreparable harm to HMOLA if not corrected before the annual enrollment period for Medicare beneficiaries begins on October 15, 2024, as the unlawful downgrade improperly skews the competitive landscape and will misinform current members and potential enrollees about the quality of the Surviving Contract. In addition to the loss of membership and other competitive harms, failure to correct at least one of these errors will also result in material adverse financial impact to BCBSLA and its subsidiaries in the form of lost quality bonus payments, which will trickle down to members in the form of fewer benefits and higher costs.

Attached is a detailed explanation of each error. If any additional information is needed, BCBSLA would invite a meeting with CMS and/ or CMS legal counsel to discuss these issues further. Thank you.

Lou Patalano
Chief Legal Officer, Senior Vice President & Corporate Secretary
Blue Cross and Blue Shield of Louisiana
5525 Reitz Avenue
Baton Rouge, Louisiana 70809

(o) 225.295.2266
(c) 225.278.8561
lou.patalano@bcbsla.com

Please visit us at bcbsla.com/social.

Louisiana

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

HMO LOUSIANA, INC.

Plaintiff(s)

v.

U.S. Department of Health & Human Sevices, et al.

Defendant(s)

Civil Action No. 24-2931

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* U.S. Department of Health & Human Sevices
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Paul Werner
Sheppard, Mullin, Richter & Hampton LLP
2099 Pennsylvania Ave, NW, Suite 100
Washington, DC 20006
Telephone: (202) 747-1900
pwerner@sheppardmullin.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ANGELA D. CAESAR, CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No. 24-2931

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

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HMO LOUSIANA, INC.

Plaintiff(s)

v.

U.S. Department of Health & Human Sevices, et al.

Defendant(s)

Civil Action No. 24-2931

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Paul Werner
Sheppard, Mullin, Richter & Hampton LLP
2099 Pennsylvania Ave, NW, Suite 100
Washington, DC 20006
Telephone: (202) 747-1900
pwerner@sheppardmullin.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ANGELA D. CAESAR, CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

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❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

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Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

HMO LOUSIANA, INC.

Plaintiff(s)

v.

U.S. Department of Health & Human Sevices, et al.

Defendant(s)

Civil Action No. 24-2931

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Chiquita Brooks-Lasure, Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Paul Werner
Sheppard, Mullin, Richter & Hampton LLP
2099 Pennsylvania Ave, NW, Suite 100
Washington, DC 20006
Telephone: (202) 747-1900
pwerner@sheppardmullin.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ANGELA D. CAESAR, CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No. 24-2931

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Date: _____

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Server's signature

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Printed name and title

_____
Server's address

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AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

HMO LOUSIANA, INC.

Plaintiff(s)

v.

U.S. Department of Health & Human Sevices, et al.

Defendant(s)

Civil Action No. 24-2931

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Xavier Becerra, Secretary of Health & Human Services
U.S. Department of Health & Human Sevices
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

Paul Werner
Sheppard, Mullin, Richter & Hampton LLP
2099 Pennsylvania Ave, NW, Suite 100
Washington, DC 20006
Telephone: (202) 747-1900
pwerner@sheppardmullin.com

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

ANGELA D. CAESAR, CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No. 24-2931

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❒ Other *(specify):*

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Date: _____

_____
Server's signature

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Printed name and title

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Server's address

Additional information regarding attempted service, etc:

AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Columbia

HMO LOUSIANA, INC.

Plaintiff(s)

v.

U.S. Department of Health & Human Sevices, et al.

Defendant(s)

Civil Action No. 24-2931

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Matthew M. Graves, United States Attorney
United States Attorney's Office, District of Columbia
601 D Street, NW
Washington, DC 20579

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

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Sheppard, Mullin, Richter & Hampton LLP
2099 Pennsylvania Ave, NW, Suite 100
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pwerner@sheppardmullin.com

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ANGELA D. CAESAR, CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No. 24-2931

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Date: _____

_____
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Printed name and title

_____
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AO 440 (Rev. 06/12; DC 3/15) Summons in a Civil Action

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HMO LOUSIANA, INC.

Plaintiff(s)

v.

U.S. Department of Health & Human Sevices, et al.

Defendant(s)

Civil Action No. 24-2931

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Merrick B. Garland, United States Attorney General
United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are:

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pwerner@sheppardmullin.com

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_____
Server's address

Additional information regarding attempted service, etc: